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Important information about your health benefits – New Hampshire

Managed Choice[®]



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Understanding your plan of benefits

Aetna* health benefits plans cover most types of health care from a doctor or hospital, but they do not cover everything. The plan covers recommended preventive care and care you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans, but some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if the plan includes those rules.

Where to find information about your specific plan

Your “plan documents” list all the details for the plan you choose. This includes what’s covered, what’s not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can’t find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

Get plan information online and by phone

If you’re already enrolled in an Aetna health plan

You have three convenient ways to get plan information anytime, day or night:

1. Log in to your secure Aetna Navigator® member website

You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

Have your Aetna ID card handy to register. Then visit **www.aetna.com** and click “Log In/Register.” Follow the prompts to complete the one-time registration.

Then you can log in any time to:

- Verify who’s covered and what’s covered
- Access your “plan documents”
- Track claims or view past copies of Explanation of Benefits statements
- Use the DocFind® search tool to find network care
- Use our cost-of-care tools so you can *know before you go*
- Learn more about and access any wellness programs that come with your plan

2. Use your mobile device to access a streamlined version of Aetna Navigator

Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS to 23862** to download.

Here’s just some of what you can do from Aetna Mobile:

- Find a doctor or facility
- View alerts and messages
- View your claims, coverage and benefits
- View your ID card information
- Use the Member Payment Estimator
- Contact us by phone or e-mail

3. Call Member Services at the toll-free number on your Aetna ID card

As an Aetna member you can use the Aetna Voice Advantage self-service options to:

- Verify who’s covered under your plan
- Find out what’s covered under your plan
- Get an address to mail your claim and check a claim status
- Find other ways to contact Aetna
- Order a replacement Aetna ID card
- Be transferred to behavioral health services (if included in your plan)

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health insurance plans are underwritten by Aetna Life Insurance Company.

You can also speak with a representative to:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

Search our network for doctors, hospitals and other health care providers

Use our DocFind search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by Zip code, or enter a specific doctor's name in the search field.

Existing members: Visit www.aetna.com and log in. From your secure member website home page, select "Find a Doctor" from the top menu bar and start your search.

Considering enrollment: Visit www.aetna.com and scroll down to "Find a doctor, dentist, facility or vision provider" from the home page. You'll need to select the plan you're interested in from the drop-down box.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you're not yet a member, call **1-888-982-3862**.

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- **Copay** – A set amount (for example, \$25) you pay for a covered health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.
- **Coinsurance** – Your share of the costs of a covered service. Coinsurance is calculated as a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20 percent would be \$20. The health plan pays the rest of the allowed amount.
- **Deductible** – Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you have paid \$1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services. Other deductibles may apply at the same time.

Help for those who speak another language and for the hearing impaired

If you require language assistance, please call the Member Services number on your Aetna ID card, and an Aetna representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial **711** for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, y un representante de Aetna le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marcar **711** para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

- **Inpatient hospital deductible** – This deductible applies when you are a patient in a hospital.
- **Emergency room deductible** – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

The inpatient hospital and emergency room deductibles are separate from your general deductible. For example, your plan may have an overall \$1,000 deductible and also has a \$250 emergency room deductible. This means you pay the first \$1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first \$250 of that bill.

Your costs when you don't get a referral or you go outside the network

You may choose a doctor in our network with or without a PCP referral. You may also choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

"Preferred" benefits means you must get a PCP referral to network doctors to receive the highest level of benefits for specialty care. (See the "Referrals" section for more about this.) If you don't get a referral, your benefit will be paid at the "nonpreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

"Out of network" means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount the plan doesn't "recognize." You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the "usual and customary" charge or "reasonable amount" rate. These plans use information from FAIR Health, Inc., a not-for-profit company, that reports how much providers charge for services in any Zip code.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you *choose* to get care out of network. See "Emergency and urgent care" to learn more.

Going in network just makes sense.

- We have negotiated discounted rates for you.
- Network doctors and hospitals won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

Choose a primary care physician

With an Aetna Point of Service (POS) plan, you are covered at different levels depending on whether you visit your chosen primary care provider (PCP), or if you go directly to any licensed physician without seeing your PCP first.

Your PCP can coordinate all your health care. If it's an emergency, you don't have to call your PCP first. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed.

If you visit any licensed physician without going to your PCP first, your out-of-pocket costs are generally higher.

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child(ren)'s PCP. Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. He or she will issue referrals to other doctors (if your plan requires referrals). He or she will also get approvals you may need and comply with any treatment plans you are on. See the sections about referrals and precertification for more information.

Tell us who you chose to be your PCP

Each member of the family may choose a different PCP from the Aetna network. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

Referrals: Your PCP will refer you to a specialist when needed

To receive the highest level of benefits under the plan, you will need to get a referral from your PCP before you can see a network specialist.

A “referral” is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There’s no paper involved! Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See “PCP and referral rules for Ob/Gyns” for more.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

PCP and referral rules for obstetricians and gynecologists (Ob/Gyn)

A female member can choose an Ob/Gyn as her PCP. Women can also go to any Ob/Gyn who participates in the Aetna network without a referral or prior authorization. Visits can be for:

- Checkups, including breast exam
- Mammogram
- Pap smear
- Obstetric or gynecologic problems

Also, an Ob/Gyn can give referrals for covered obstetric or gynecologic services just like a PCP. Just follow your plan’s normal rules. Your Ob/Gyn might be part of a larger physician’s group. If so, any referral will be to a specialist in that larger group. Check with the Ob/Gyn to see if the group has different referral policies.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that’s required.

Your plan documents list all the services that require you to get precertification. If you don’t, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

Call the number on your Aetna ID card to begin the process. You must get the precertification before you receive the care.

You do not have to get precertification for emergency services.

What we look for when reviewing a request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. Our decisions are based entirely on appropriateness of care and service and the existence of coverage using nationally recognized guidelines and resources. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Our review process after precertification (Utilization Review/Patient Management)

We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a “utilization review.”

We follow specific rules to help us make your health a top concern during our reviews

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review requests for coverage. Physician groups, such as independent practice associations, may use other resources they deem appropriate.
- We do not encourage utilization decisions that result in underutilization.

Information about specific benefits

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, follow these guidelines:

- Call **911** or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

You are covered for emergency care

You have emergency coverage while you are traveling or if you are near your home. That includes students who are away at school.

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain after a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. When you have no choice, we will pay the bill as if you got network care. You pay your plan's copayments, coinsurance and deductibles for your network level of benefits.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

Follow-up care for plans that require a PCP

If you use a PCP to coordinate your health care, your PCP should also coordinate all follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care – available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to www.aetna.com and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits.

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

When you get a drug that is not on the preferred drug guide, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug companies may give us rebates when our members buy certain drugs

We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percentage of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

Mail-order and specialty-drug services from Aetna owned pharmacies

Mail-order and specialty drug services are from pharmacies Aetna owns. These pharmacies are called Aetna Rx Home Delivery and Aetna Specialty Pharmacy, which are for-profit pharmacies.

You might not have to stick to the preferred drug guide

Sometimes your doctor might recommend a drug that's not in the preferred drug guide. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
“Step-therapy” means you may have to try one or more less-expensive or more common drugs before a drug on the step-therapy list will be covered. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Some drugs are not covered at all

Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

New drugs may not be covered

Your plan may not cover drugs we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug guide

You can find the Aetna Preferred Drug Guide on our website at www.aetna.com/formulary/. You can call the toll-free number on your Aetna ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates.

Have questions? Get answers.

Ask your doctor about specific medications. Call the number on your Aetna ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Mental health and addiction benefits

Here's how to get inpatient and outpatient services, partial hospitalization and other mental health services:

- Call **911** if it's an emergency.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists

We want you to feel good about using the Aetna network for mental health services. Visit www.aetna.com/docfind and click the “Quality and Cost Information” link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Aetna Behavioral Health offers two screening and prevention programs for our members

- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **SASADA Program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

Call Member Services to learn more about these programs.

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Important benefits for women

Women's Health and Cancer Rights Act of 1998

Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents. Please contact Member Services for more information.

For more information, visit the U.S. Department of Health and Human Services website, www.cms.gov/HealthInsReformforConsume/Downloads/WHCRA_Helpful_Tips_2010_06_14.pdf, and the U.S. Department of Labor website, www.dol.gov/ebsa/consumer_info_health.html.

No coverage based on U.S. sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Knowing what is covered

Here are some of the ways we determine what is covered:

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition, or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part
- Must be known to help the particular symptom
- Cannot be for the member's or the doctor's convenience
- Cannot cost more than another service or product that is just as effective

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physicians' group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physicians' group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit www.aetna.com/about/cov_det_policies.html to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies. To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

We write a report about a product or service after we decide if it is medically necessary. We call the report a Clinical Policy Bulletin (CPB).

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at www.aetna.com. You can find them under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate complaint department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that says your claim was denied. The letter also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal (in most cases you will need to finish all of your internal appeals first). Follow the instructions on our response to your appeal. Call Member Services to ask for an external review form. You can also visit www.aetna.com. Enter "external review" into the search bar.

An independent review organization (IRO) will assign your case to one of their experts. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request. The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision and you will not have to pay anything unless there was a filing fee.

A "rush" review may be possible

If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means we will make our decision as soon as possible.

Member rights and responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our member rights and responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit www.aetna.com/individuals-families/member-rights-resources.html to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Patients' Bill of Rights

As a patient, you have the right to:

1. Be treated with consideration, respect, and dignity as an individual. You should receive treatment and personal care in private. You're allowed to ask for the name, licensure status, and staff positions of anyone that comes in contact with you.
2. Know your rights and responsibilities. Hospital staff must tell you or list them in writing before or when you are admitted. This does not include emergencies. You or someone on your behalf must acknowledge in writing that you received the information.
3. Know how much it costs to be a patient in a hospital. You also have a right to know about any services Medicare or Medicaid does not cover. Hospital staff must give you this information in writing and in a language you can understand when you arrive.
4. Understand your medical condition, health care needs and any test results. Your doctor should tell you how and when you'll receive this information. You may help plan your total care and medical treatment. You can refuse treatment. You may give your consent to and be involved in experimental research.
5. Be transferred or discharged only if:
 - Your doctor feels it is medically safe to do so
 - The hospital goes out of business
 - The law allows the hospital to discharge you for nonpaymentA hospital may not send you home simply because you are eligible for Medicaid.
6. Get help exercising your rights. You may voice a complaint. You can suggest changes in hospital policies and services. The hospital cannot prevent or interfere with your right to do so. Nor can they intimidate you, discriminate against you or retaliate against you because of it.
7. Manage your personal financial affairs. If you authorize the facility to help you manage your finances, they must do so with regard to your legal rights.
8. Be free from emotional, mental, sexual and physical abuse. Health care workers may not exploit, neglect or punish you. They may not seclude you without your agreement.

9. No restraints unless your doctor authorizes it in writing. Any restraint must be for a limited time and only to protect you and others. In an emergency, a designated professional staff member may also authorize restraints to protect you and others. The staff member must promptly report and document such action in your medical records.
10. Have your personal and clinical records kept private. You must give your consent in writing before anyone can release your information unless the law allows it. Your medical information is your property. You can ask your doctor to give you a copy of your records. The doctor may charge you up to \$15 for the first 30 pages or \$.50 per page, whichever is greater. You can also get copies of filmed records such as radiograms, X-rays and sonograms at a reasonable cost.
11. Not perform services for the facility. They can give you tasks to perform as therapy or as a diversion if included in the plan for your care and treatment.
12. Contact with family and resident groups, unless it infringes on the rights of other patients. You may send and receive unopened personal mail. You have the right to unmonitored phone calls.
13. Participate in social, religious and community activities, as long as it does not violate the rights of other patients.
14. Use your own clothing. You can also keep your possessions as long as there's room and it does not violate the rights of other patients.
15. Privacy for visits. You can share a room with your spouse if he or she is also a patient in the same facility and consents. An exception would be if your doctor thinks sharing a room may be harmful to your or your spouse's health. You have the right to have your needs and preferences met. This includes your choice of room and roommate, unless your choice would be a danger to your health and safety or to other patients.
16. Get the same care as anyone else, without regard for your race, religion, color, national origin, sex, age, disability, marital status, source of payment or sexual orientation.
17. Choose your treating doctor. You must honor any reasonable rules the facility has for the doctor's credentials.
18. Have no restrictions on visitors if you are terminally ill.
19. Have visits from those who represent organizations that the law approves.
20. Be admitted even when Medicaid is your source of payment, as long as there is room to admit you.
21. Use doctors, labs and health care products and services from network providers. This will be subject to the terms and conditions of your insurance plan.

Making medical decisions before your procedure

An "advance directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advance directive to receive care, but you have the right to create one. Hospitals may ask if you have an advance directive when you are admitted.

There are three types of advance directives:

- Durable power of attorney – Names the person you want to make medical decisions for you
- Living will – Spells out the type and extent of care you want to receive
- Do-not-resuscitate order – States you don't want CPR if your heart stops or a breathing tube if you stop breathing

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at <http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html>. Accessed January 12, 2015.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at www.aetna.com. Enter "commitment to quality" in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your Aetna ID card.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By “personal information,” we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna Privacy Policy

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs), (this includes plan sponsors and/or employers)

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

For more information about our privacy notice or if you'd like a copy, call the toll-free number on your ID card or visit us at www.aetna.com.

Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are legally required to the same.

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

How we use information about your race, ethnicity and the language you speak

You choose if you want to tell us your race, ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See “We protect your privacy” to learn more about how we use and protect your private information. See also “Anyone can get health care.”

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Continuing health care benefits

There are many reasons you and your covered dependents can get new coverage if you lose your eligibility for or coverage under this health plan.

You can continue coverage

- **If your group coverage ends for any reason other than your gross misconduct:**

- For 18 months or for 29 months if you or your dependent is disabled. You must notify your employer of the disability within 60 days of the original coverage end date.
- Until you become eligible for similar group benefits.
- As long as payment continues, until the end of the 18 or 29 months.

Coverage for a dependent will not be continued beyond the date it would otherwise terminate.

- **If your group coverage ends because you're no longer a member of an eligible class of employee:**

- For up to 39 weeks. We'll subtract any weeks your coverage was already continued during a strike, lockout or labor dispute. If coverage is being continued for a second reason (see above) when you lose eligibility due to a change in employee class, you can continue for up to the remainder of the 18- or 29-month period specified above.
- Until you become eligible for similar group benefits.
- As long as payment continues for the allowed duration.

In both cases, you must ask to continue coverage within 45 days of our notice to you or the date coverage would otherwise terminate, whichever comes later. You must agree to pay up to 102 percent of the cost to the plan. You must continue to make the monthly payments.

Once your continued coverage reaches the maximum period, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit www.HealthCare.gov.

Your child can continue coverage

If your eligible child no longer meets this plan's definition of dependent, he or she may continue the coverage then in force.

Your child must ask to continue coverage within 45 days of our notice, or the date coverage would otherwise terminate, whichever comes later. The child must agree to pay up to 102 percent of the cost to the plan and continue to make the monthly payments.

Continued coverage will end:

- 36 months after the coverage end date. If the coverage involved would end during the 36-month period because your employee eligibility class changes, your child's coverage will continue as if there was no change. That is, until 39 weeks from the date of the discontinuance or the remainder of the 36-month period, unless coverage ends for another reason.

- When your child becomes eligible for similar group benefits.
- As long as payment continues for the coverage.

If any continued coverage reaches the maximum period, your child may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit www.HealthCare.gov.

Continuing coverage for special cases

Dependent students on medical leave of absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- A medically necessary leave of absence from school; or
- A change in his or her status as a full-time student, resulting from a serious illness or injury, such child's coverage under this plan may continue coverage under this continuation provision will end when the first of the following occurs:
 - The end of the 12-month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
 - Your dependent child's coverage would otherwise end under the terms of this plan;
 - Dependent coverage is discontinued under this plan; or
 - You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision, you should notify us or your employee as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student.

Documentation and certification of the medical necessity of the leave of absence shall be submitted to Aetna by the student's treating physician and shall be considered evidence of entitlement to coverage. The medical leave of absence shall begin on the date the documentation and certification of the medical necessity were obtained from the physician.

Important Note:

If at the end of this 12-month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the "Your child can continue coverage" section for more information.

Your handicapped child can continue coverage

You can include your handicapped dependent child on your health plan past the maximum age. You may not include your handicapped child if he or she has been issued an individual medical policy. You may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit www.HealthCare.gov.

You must send proof that your child is fully handicapped no later than 31 days after he or she reaches the maximum age. Your child is fully handicapped if:

- He or she is not able to earn a living because of a mental or a physical handicap. This handicap will have started before he or she reached the maximum age for dependent children under your plan.
- He or she depends chiefly on you or your estate for support and maintenance.

You must submit proof that your child is fully handicapped no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will end on the first to occur of:

- Cessation of the handicap
- Your child ceases to be financially dependent on you; or you or your estate is no longer chargeable for your dependent's care
- Premiums cease to be paid for your child's coverage
- Your child's dependent coverage ends for any reason other than reaching the maximum age under the plan

If:

- any health coverage for dependents under this plan replaces health coverage under any group or blanket plan; and
- the prior plan contained a handicapped dependent children provision;

then any child to whom that provision applied who was covered under the prior plan on the day before the effective date of this plan will be entitled to coverage under this plan subject to terms of this provision.

Important note:

Your dependent may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit www.HealthCare.gov.

Retirees of bankrupt former employers can continue coverage

If your former employer files for bankruptcy, you may choose to keep your health and dental coverage for yourself and your dependents. Your dependents may also continue his or her own coverage.

Just send a written request to continue your coverage. We must receive your request within 45 days of the bankruptcy date or our notice to you or your dependents of your right to continue coverage, whichever comes later. You must agree to pay up to 102 percent of the cost of the plan. You must continue making your premium payments.

Continued coverage will stop when the first of the following occurs:

- 36 months after the date coverage would otherwise terminate.
- You (or your dependent) become eligible for similar coverage.
- The end of the period for which you last made your premium payment.
- The date of the first Medicare open enrollment period after you (or your dependent) became eligible for Medicare.

Those impacted by a labor dispute can continue coverage

You can arrange to continue your coverage while you're out of work because of a strike, lockout or a labor dispute. Coverage may continue for up to 6 months after your compensation ends.

Continuation will end when the first of these events occurs:

- You fail to pay your share of the premium to your employer
- Your employer fails to pay us
- You go to work full time for another employer
- The strike, lockout or labor dispute ends
- The six-month continuation period ends. You can choose to extend this for an additional 12 months. At the end of those 12 months, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit www.HealthCare.gov.

You'll pay the same rate that was in effect on the date you stopped working. We have the right to change premium rates. We will notify you 60 days before doing so.

Divorced or legally separated spouses can continue coverage

Your former spouse is eligible for coverage as a dependent while the policy remains in force or if you replace it with another policy that covers your former spouse. You and/or your employer must continue to pay the premiums.

Coverage will end when the first of the following occurs:

- Three-year (36 month) anniversary of final decree of the divorce or legal separation
- Former spouse remarries
- You remarry
- You die
- Any earlier time provided in final divorce or legal separation

Except if the former spouse remarries, if any of these other situations occur, your former spouse can request to continue coverage in writing within 30 days from the first of:

- Three-year (36 month) anniversary of final decree of the divorce or legal separation
- Your marriage to another
- Your death
- Any earlier time provided in final divorce or legal separation

Unless your former spouse is age 55 or older, coverage will end after 36 months or after payment stops, whichever comes first. If your former spouse is 55 years or older, coverage must continue until he or she is eligible under another employer-based group plan or becomes eligible for Medicare.

If any continued coverage reaches the maximum period, the former spouse may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit

www.HealthCare.gov.

Your surviving dependents can continue coverage

If you die, your dependents must request continued coverage in writing within 45 days of our notification to them, or the date coverage would otherwise end. They must agree to pay up to 102 percent of the cost to the plan and continue to make the monthly payments.

Continued coverage will end:

- 36 months after the date of your death. If the coverage would end during the 36-month period because your employee eligibility class changes, your dependent's coverage will continue as if there was no change. That is, coverage will continue until 39 weeks from the date of the discontinuance or the remainder of the 36-month period, unless coverage ends for another reason.
- When the dependent becomes eligible for similar group benefits.
- As long as payment continues for the coverage.

A child born after your death can also get coverage as long as coverage for your other dependents continues.

If any continued coverage reaches the maximum period, the dependent may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit **www.HealthCare.gov**.

Your dependents can continue coverage after you become eligible for Medicare

Your dependents must make their request in writing within 45 days of our notification to them or the date coverage would otherwise terminate. They must agree to pay up to 102 percent of the cost to the plan. They must continue to make the monthly payments.

Continued coverage will end:

- 36 months after the date you become Medicare eligible. If the coverage involved would end during the 36-month period because your employee eligibility class changes, your dependent's coverage will continue as if there was no change. That is, coverage will continue until 39 weeks from the date of the discontinuance or the remainder of the 36-month period, unless coverage ends for another reason.
- When the dependent becomes eligible for similar group benefits.
- As long as payment continues for the coverage.

If any continued coverage reaches the maximum period, the dependent may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the marketplace, visit **www.HealthCare.gov**.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete list of health plans and their NCQA status can be found on the NCQA website located at <http://reportcard.ncqa.org>.

To refine your search, we suggest you search these areas:

- 1. Health Insurance Plans** – for HMO and PPO health plans and
- 2. Physicians and Physician Practices** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections–Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

See “Other Reports on Health Care Quality” in the drop-down menu for Managed Behavioral Healthcare Organizations – for behavioral health accreditation and Credentials Verifications Organizations – for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-888-982-3862.

Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.